STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P. 0. Box 942732
/SACRAMENTO, CA 94234-7320
(916) 654-8076

February 20, 1998

MMCD Policy Letter 98-05

RECEIVED
FEB 23 1998

TO:
[X] Prepaid Health Plans
[X] County Organized Health Systems
[X] Primary Care Case Management Plans
[X] Two-Plan Model Plans
[X] Geographic Managed Care Plans

SUBJECT: ENROLLMENT OF MEDI-CAL/MEDICARE DUAL ELIGIBLES AND MEDI-CAL BENEFICIARIES WITH COMMERCIAL HEALTH MAINTENANCE ORGANIZATION COVERAGE

GOAL

The purpose of this letter is to provide Department of Health Services' policy regarding the enrollment in Medi-Cal managed care plans (MCP) of Medi-Cal beneficiaries who are also covered by the Medicare program (dual eligibles) or have private commercial health plan coverage.

BACKGROUND

Medi-Cal beneficiaries who are covered by the Medicare program have the option to receive Medicare coverage on a fee-for-service (FFS) basis or through membership in a health maintenance organization (HMO) contracting with the federal government. Dual eligibles enrolled in a Medicare HMO have an Other Health Coverage (OHC) code of "F" on the Medi-Cal eligibility file. Most California Medicare HMOs offer benefits to their Medicare members that are broader than the Medicare FFS benefit package.

In general, the Medi-Cal program will cover and pay for Medi-Cal covered health care services provided to dual eligibles under three circumstances:

1. The service provided to the beneficiary is covered by the Medi-Cal program, but is not covered by the Medicare FFS program or the Medicare HMO in which the beneficiary is enrolled.

2. The Medi-Cal beneficiary has exhausted his or her annual or lifetime Medicare FFS or Medicare HMO benefit coverage for the services billed.

3. The beneficiary receives Medicare on a FFS basis and has incurred a Medicare co-insurance or deductible obligation and the amount Medicare has paid the provider is less than the amount the Medi-Cal program would have paid the provider had the service been billed to the Medi-Cal program. Medi-Cal will pay the difference up to the Medi-Cal allowed rate for the Medi-Cal covered service, which may include the co-insurance or deductible.

The Medi-Cal program is by law the payor of last resort; therefore, before billing the Medi-Cal program, Medi-Cal health care providers are required to bill the Medicare program (or any other commercial HMO in which a Medi-Cal beneficiary may be enrolled) and, in circumstances 1 and 2 above, obtain a denial notice or confirmation that Medicare (or commercial HMO) benefits have been exhausted or are not covered. Medi-Cal MCP capitation rates assume that Medi-Cal MCP contractors will similarly direct their providers to obtain, or the plan will otherwise arrange for, reimbursement from the Medicare FFS program or the responsible Medicare (or commercial) HMO before assuming the obligation to cover and pay for a service provided to a dual eligible.

POLICY

It is the policy of the Department that, except for Medi-Cal county organized health systems (COHS), the Program of All-Inclusive Care for the Elderly (PACE) projects, or a Medi-Cal contracting social HMO:

1. Dually eligible Medi-Cal beneficiaries who receive their Medicare services through membership in a Medicare HMO may *not* be members of a Medi-Cal MCP unless the plan has met the conditions described in the next section of this letter. As noted above, these dual eligibles will be identified with an OHC code of "F."

2. Medi-Cal beneficiaries with any of the following OHC codes designating membership in a privately paid commercial HMO may *not* be members of a Medi-Cal MCP:

   - "C" (CHAMPUS Prime HMO)
   - "K" (Kaiser HMO)

- "P" (other HMO/PHP coverage, or other coverage when the enrollee is limited to a prescribed panel of providers for comprehensive services, excluding CHAMPUS, Kaiser, or Medicare)

3. Dually eligible Medi-Cal beneficiaries who receive their Medicare services on a FFS basis or who have non-HMO commercial health insurance coverage may voluntarily enroll in any Medi-Cal MCP, if they otherwise are eligible to be a Medi-Cal plan member.

4. Medi-Cal beneficiaries who receive Supplemental Security Income (SSI) and who experience OHC problems may call the Department's Third Party Liability Branch toll-free at l-800-952-5294 for assistance. Medi-Cal beneficiaries who do not receive SSI and who experience OHC problems may call their County Welfare Office for assistance.

Conditions for Enrollment of Dual Eligibles With Medicare HMO Coverage

A Medi-Cal MCP, other than a COHS, PACE, or a social HMO, may enroll dual eligibles with Medicare HMO coverage only if the following conditions are met:

1. The Medi-Cal MCP contractor enrolling the beneficiary must also be the Medicare HMO in which the beneficiary is enrolled. A health plan subcontracting with a- Medi-Cal MCP contractor to provide services under the Medi-Cal MCP's contract with the Department does not meet this condition.

2. The Medi-Cal MCP must submit a written proposal to the Department that includes a comparison between the Medicare HMO coverage that will be provided to its dually eligible members and the Medi-Cal benefits package, and it must reach agreement with the Department on any required adjustments to the plan's Medi-Cal capitation rates.

   The Department will adjust the plan's Medi-Cal capitation rates when the plan provides its Medicare HMO members expanded benefits coverage that is beyond basic Medicare FFS benefits coverage and that duplicates coverage for which the plan would be reimbursed by the Medi-Cal program. For example, the Medi-Cal capitation rates assume that little or no pharmacy coverage will be provided under the Medicare program to dual eligibles. An adjustment to the Medi-Cal capitation rates could be required before a plan was allowed to

enroll Medi-Cal plan members into the plan's Medicare HMO, if the plan offered a pharmacy benefit to its Medicare HMO members.

3. The Medi-Cal contract with the plan must be amended formally to include authorization for the plan to enroll its Medi-Cal members into its Medicare HMO and incorporate into the contract any rate adjustments or other agreements developed under the process described in 2 above.

Systems Edits

The Department's enrollment contractor has established an edit in their system that precludes beneficiaries with an OHC code of F, K, C, or P from being enrolled in a Medi-Cal MCP through the Health Care Options Program.

An edit has been installed in the Medi-Cal Eligibility Data System (MEDS) which will disenroll beneficiaries whose MEDS records are updated after enrollment to add one of the excluded OHC codes.

It is the intent of the Department to initialize the MEDS OHC edit in the near future. Advance notice of the effective date of this action will be sent to affected beneficiaries and to plans. When the MEDS edit is activated, each plan member with an excluded OHC code will be placed on a two-month "hold" status for purposes of plan membership. The MEDS system will only show the member as eligible for FFS coverage.

If the OHC for a member in "hold" status is incorrect and the member arranges with County Welfare to have their eligibility record cleared of the incorrect code prior to the MEDS renewal date in the second month of hold, plan membership will automatically be reestablished. If the OHC code is correct or the member's MEDS record is not corrected prior to the renewal date in the second "hold" month, the member will be disenrolled.

Submission of Letter of Intent and Proposal

Medi-Cal MCPs which are also Medicare HMOs and wish to enroll and/or retain their Medi-Cal plan members under both plans must submit a letter of intent to submit a proposal to retain these members to their contract manager within 30 days of the date of this policy letter.

The plan must submit the formal written proposal described above within 60 days of the date of this letter and enter into negotiations with the Department to enroll and/or retain these members. Otherwise, the Department will implement the MEDS edit to disenroll Medi-Cal MCP members who are also enrolled in the plan's Medicare HMO and to prohibit their enrollment.

If you need more information or have additional questions, please contact your contract manager.

Ann-Louise Kuhns, Chief
Medi-Cal Managed Care Division

STATE OF CALIFORNIA–HEALTH AND WELFARE AGENCY

DEPARTMENT OF MENTAL HEALTH
1600 - 9TH STREET
SACRAMENTO, CA 958 I 4
16) 654-1615

TP EC
JP MT
DB PB
CT GG
KS

January 16, 1998 ,

To: County Mental Health Directors:

Enclosed is a copy of the Department of Health Services' draft policy letter to its health plans regarding interface with mental health plans under Phase II consolidation. Please review the draft carefully and provide me with your written comments by February 3, 1998. Comments are also being requested from the health plans.

Although the policy letter will directly affect only those counties in which health plans are operating, comments from any county will be appreciated. Comments should be sent to my attention at: Department of Mental Health, 1600 9th Street, Room 120, Sacramento, CA 95 8 14. If you have questions or need additional information. please call me at (9 16) 654-16 15.

Sincerely,

TERI BARTHELS, Chief
Managed Care Implementation

Enclosure

Pam → Please cc: Maribel Ochoa)
Thanks
Reggie

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY PETE WILSON. Governor

DEPARTMENT OF HEALTH SERVICES
1744 P STREET
P. O. Box 942732
SACRAMENTO, CA 94234-7320
(916) 654-8076

MMCD Policy Letter No. 97-

TO:
(X) Prepaid Health Plans (PHP)
(X) County Organized Health Systems (COHS)
(X) Primary Care Case Management (PCCM) Plans
(X) Two-Plan Model Plans
(X) Geographic Managed Care (GMC) Plans

SUBJECT: MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES UNDER MEDICAL SPECIALTY MENTAL HEALTH SERVICES CONSOLIDATION

Goal

The goal of this letter is to explain Medi-Cal managed care plans (MCP) contractual responsibilities following local Mental Health Plan (MHP) implementation under Medi-Cal Specialty Mental Health Services Consolidation.

Background

The Health Care Financing Administration (HCFA) has approved California's request for waiver authority to renew and amend the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation program which has been effective since January 1995. HCFA has approved a modification to this waiver to include outpatient specialty mental health and certain skilled nursing facility services. This waiver program is now known as the Medi-Cal Specialty Mental Health Services Consolidation program. Uncier the Consolidation program, coverage

for most Medi-Cal covered specialty mental health *services will be* provided only through MHPs in California's 58 counties. In most cases, the MHP will be the county mental health department.

Each MHP will directly provide, or authorize 2nd pay for, Medi-Cal inpatient and outpatient specialty mental health services for Medi-Cal residents of the county served by the MHP as described in this letter. Most Medi-Cal MCP contracts have been, or will be, amended to remove responsibility for the FFS/Medi-Cal specialty mental health services delivered by MHPs. For MCPs whose contracts still include specialty mental health services coverage, amendments to exclude this coverage will be issued with an effective date concurrent with the date the county MHP begins operation.

MHP Implementation

MHP implementation began November 1, 1997, and is expected to continue through July 1, 1998. Alameda, Kern, Placer, Riverside, and San Joaquin Counties implemented their MHPs effective November I, 1997. MHP implementation in Lassen, Marin, Mariposa, Mendocino, Monterey, Orange, Shasta, Siskiyou, Stanislaus, 2nd Yolo Counties will take effect January 1, 1998. Most remaining counties will implement their MHPs by April 1, 1998. MHP implementation in San Diego County has been postponed to July 1, 1398.

Specialty Mental Health Services

Specialty mental health services are service; delivered by appropriately licensed specialty mental health providers. Appropriately licensed specialty mental health providers

are psychiatrists; psychologists; and licensed clinical social workers (LCSW); marriage, family, and child counselors (MFCC); and master's level registered nurses who are Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental service providers.

MHP Covered Services

Under the Consolidation program, MHPs w-iii be responsible for most Medi-Cal covered specialty mental health services previously funded through FFS/Medi-Cal. These services comprise the following:

- Rehabilitative Services including mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis intervention services, and psychiatric health facility services;.
- Psychiatric Inpatient Hospita! Services;
- Targeted Case Management;
- Psychiatrist Services;
- Psychologist Services;
- EPSDT Supplemental Specialty Mental Health Services; and
- Psychiatric Nursing Facility Services.

The HCFA Common Procedural Coding System (HCPCS) Codes for services covered by MHPs are listed on Table I.

MHPs will provide these services oniy when:

3. The beneficiary has a particular diagnosis ("included diagnosis"), outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM IV); *and*

2. The qualifying mental health condition also meets MHP medical necessity criteria. Adults with included diagnoses must have a significant impairment in an important area of life functioning, or the probability of significant deterioration in an important area of Iife functioning. Further, intervention must be expected to either significantly diminish impairment in, or prevent significant deterioration of, an important area of life functioning. Children with included diagnoses will qualify if there is a probability that the child would not progress developmentally as individually appropriate. Children covered under the EPSDT Program till qualify if they have an included diagnosis which may be corrected or ameliorated by intervention.

Table *2 lists the International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for the MHP covered mental health conditions. Table 3 summarizes the criteria which will be used by the MHP to determine the beneficiary's medical necessity for specialty mental health treatment.

Specialty mental health services for "included diagnoses" will only be available through MHPs. Coverage under the FFS/Medi-Cal program for these services will be discontinued. The MHP will not provide specialty mental health treatment when an included diagnosis would be responsive to primary physical health care or other interventions as determined by the application of the criteria on Table 3.

A specified set of diagnoses, "excluded diagnoses", pertaining primarily to developmental disability, dementia, and substance abuse will be excluded from MHP coverage for adults and children. Medi-Cal covered outpatient specialty mental health services for treatment of "excluded diagnoses" will typically continue to be provided through the Medi-Cal FFS program unless MCPs elect to cover these diagnoses.

Medi-Cal FFS and managed care beneficiaries with "included diagnoses" who do not meet MHP treatment criteria, and beneficiaries with "excluded diagnoses", will be referred for treatment to the Medi-Cal FFS program, to their Medi-Cal MCP, or to other treatment or referral resources within the community, as appropriate. (See Table 4.)

The Department of Health Services (DHS) issued a Medi-Cal Bulietin in September 1997, to alert providers to the implementation of the Consolidation program. This Bulletin references the applicable service and diagnosis codes discussed above, and it includes a sample of the Medi-Cal beneficiary notice explaining delivery of mental health services following MHP implementation. This Bulletin is enclosed for your reference (See Exhibit).

Policy

I. MCPs with Continued Responsibility for Specialty Mental Health Services

Following local MHP implementation, most MCPs will have Medi-Cal specialty mental health services coverage excluded under their contracts. However, certain MCPs will retain responsibility for both physical health care and specialty mental health services. The Program of All-Inclusive Care for the Elderly (PACE) and pre-PACE health plans, the Senior Care Action Network (SCAN), and the Partnership HealthPlan of California (formerly the Solano Partnership Health Plan) will continue to be responsible contractually for the Medi-Cal inpatient psychiatric hospital services and specialty mental health services which would otherwise be delivered by the MHP. In addition, the contractual responsibilities of the Family Mosaic Project will remain unchanged after local MHP implementation. Other MCPs may retain responsibility for Medi-Cal specialty mental health services as an outgrowth of local negotiations between the MCP and MHP that result in an agreement for the MCP to retain coverage for mental health services under its contract with the State or for the MCP to contract directly with the MHP to provide these services.

II. MCP Responsibility for Medically Necessary Physical Health Care Services

Following local MHP implementation, all contracting MCPs (COHS, PHP, PCCM, GMC, and Two-Plan Model) will continue to be responsible for providing MCP enrollees who require specialty mental health services with contractually covered, medically necessary physical health care services. MCP capitation rates reflect continued MCP responsibility for all Medi-Cal covered physical health care services, unless specific components have been excluded by contract. MCPs remain responsible to arrange *or* provide reimbursement for the following services.

Emergency Room Services

MCPs are responsible for the emergency room physician (except for specialty mental health providers as described below) and facility charges for emergency room visits which do not result in a psychiatric inpatient admission. The MCP is nor responsible for facility charges which are followed by a psychiatric inpatient admission.

MCPs are responsible for emergency room professional services described in Title 22, California Code of Regulations (CCR), Section 53216 and, for Two-Plan Model plans, Section 53855. MCPs are not responsible for the professional component of emergency room services provided by psychiatrists, psychologists, LCSWs, MFCCs, or other specialty mental health providers.

MHPs are responsible for all psychiatric consultation charges, whether or not the consultation results in an psychiatric inpatient admission. MHPs also are responsible for emergency room facility charges which are followed by a psychiatric inpatient admission. When an emergency room psychiatric consultation results in a separate facility charge, the separate facility charge also is the responsibility of the MHP, whether or not the psychiatric consultation results in a psychiatric inpatient admission.

Physician Services

MCPs are contractually responsible for mental health services within the Primary Care Physician's (PCP) scope of practice, for both enrolled beneficiaries with excluded diagnoses and for beneficiaries with included diagnoses whose conditions do not meet MHP impairment and intervention criteria. MCPs must provide medical case management for enrolled beneficiaries and to coordinate services with the MHP referral provider and specialists treating

excluded diagnoses. MC? PCPs will refer to the MHP only when they are reasonably certain or unable to determine that an enrolled beneficiary's condition is an included diagnosis and would not be responsive to primary care.

Pharmaceutical Services and Prescription Drugs

MCPs are contractually responsible for the provision to enrollees of medically necessary pharmaceutical services and prescribed drugs described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, Section 5 13 i 3. in&ding psychotherapeutic drugs, unless they are provided as inpatient psychiatric hospital-based ancillary services or unless these drugs have been specifically excluded under the MCP contract. MCPs are responsible for providing enrollees with medications prescribed by out-of-plan psychiatrists for the treatments of mental illness. MCPs may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists; however, application of utilization review procedures should no; inhibit enrollee access to mental health prescriptions. MCPs are not responsibie for covering prescriptions written by out-of-plan physicians who are not psychiatrists, unless these prescriptions are written by non-psychiatrists contracted by the MHP to provide *mental* health services in areas (i.e. rural areas) where access to psychiatrists is limited.

Under the Two-Plan Model, reimbursement to pharmacies for the psychotherapeutic drugs listed in Table 5 (Excluded Psychotherapeutic Drugs) and for psychotherapeutic drugs classified as anti-psychotics and approved by the FDA after July 1, 1997, will be made by DHS through the FFS/Medi-Cal program, whether these drugs are provided by a pharmacy contracting with the health plan or by an out-of-plan pharmacy provider. To qualify for reimbursement. a pharmacy must be enrolled as a Medi-Cal provider in the FFS/Medi-Cal program.

Laboratory, Radiological, and Radioisotope Services

MCPs are contractually responsible for providing medically necessary laboratory, radiological, and radioisotope services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, Section 513 I I. MCPs must provide these services to enrolled beneficiaries who require the specialty mental health services of MHP or FFS providers, when they are necessary for the diagnosis and treatment of the enrollee's mental health condition. MCPs must coordinate these services with the enrollee's specialty mental health provider.

Home Health Agency Services

MCPs are responsibie for the home health agency services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, Section 51337 when medically necessary to meet the needs of homebound MCP enrollees. A homebound MCP enrollee is a patient "who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relatively short duration, e.g., for a short walk prescribed as therapeutic exercise." (Title 22, CCR, Section 5 1 136). MCPs are not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program. For example, MCPs would not be obligated to provide home health agency services for the purpose of medication monitoring when those services are not medically necessary or for a patient who is not homebound.

Medical Transportation Services

MCPs are contractually responsible for the emergency and non-emergency ambulance, litter van, and wheelchair van medical transportation services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, Section 51323 which are necessary to provide enrollees

with access to all Medi-Cal covered services, including mental health services. MCPs are responsible for emergency medical transportation services to the nearest facility capable of meeting the needs of the patient. MCPs also are responsible for the non-emergency medical transportation services necessary to provide enrollees with access to Medi-Cal covered services, subject to a' written prescription by a Medi-Cal mental health provider. However, MCPs are not responsible for medical transportation services when the transportation is required to transfer an enrollee from one psychiatric inpatient hospital to another psychiatric inpatient hospital, or to another type of 24-hour care facility, when such transfers are not medically indicated (i.e., undertaken with the purpose of reducing the MHP's cost of providing service).

Hospital Outpatient Department Service:

MHPs are responsible for services rendered by specialty mental health providers in hospital outpatient departments and the room charges associated with these services. MHPs may establish prior authorization requirements for these services. MCPs continue to be responsible for al! other professional services and associated room charges consistent with medical necessity, and the MCP's contracts with its subcontractors and DHS.

Physical Health Care Services for Psychiatric Inpatient Hospital Patients

MCPs are contractually responsible for providing all medically necessary non-specialty professional services to meet the physical health care needs of health plan enrollees who are admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital. These services include the initial health history and physical assessment required on admission to a psychiatric inpatient hospital and any medically necessary physical medicine consultations and treatments. MHPs are responsible for all

hospital-based ancillary services, including all prescriptions included in the daily rate for these facilities.

Physical Health Care Services for Psychiatric Nursing Facility Patients

Room, board, and medical, and specialty professional services covered under the daily rate for psychiatric nursing facilities which are also institutions for mental disease (IMD) are included under the Medi-Cal Specialty Mental Health Services Consolidation program. The timing of MHP assumption of this responsibility is being negotiated with county mental health directors.

An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illnesses including medical attention, nursing care, and related services. MCPs are contractually responsible for psychiatric nursing facility services subject to contractual limits on coverage for long-term care until these services become the responsibility of the MHP.

When MHPs assume responsibility for psychiatric nursing facility services, MCPs will continue to be contractually responsible for providing MCP enrollees with all medically necessary non-specialty professional and medical services not included under the IMD daily rate. With the exception of COHSs, MCPs (2-Plan, GMC, PCCM, PI-I?) will continue to submit a disenrollment request for enrollees whose projected length of stay in an IMD would exceed the month of admission plus one month, consistent with existing contractual requirements regarding nursing facility services.

III. Specialty Mental Health Services Provided by Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Centers

Specialty mental health services provided by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Centers (IHC) are not included in the waiver for the Specialty Mental Health Services Consolidation program. Specialty mental health services provided by FQHCs, RHCs, and IHCs to beneficiaries enrolled in an MC? which is not contractually responsible for specialty mental health services or in the FFS/Medi-Cal program will be reimbursed through the FFS/Medi-Cal program.

IV. EPSDT Supplemental Specialty Mental Health Services

MHPs are contractually responsible for providing specialty mental health services to EPSDT beneficiaries with included diagnoses, whose mental health condition may be corrected or ameliorated and would not be responsive physical health care treatment. EPSDT beneficiaries with an included diagnosis and a substance-related disorder may receive specialty mental health services directed at the substance-use component. MCPs should refer EPSDT eligible enrollees whom they are reasonably certain would meet MHP diagnostic criteria to the MHP for assessment and treatment. PCCMs will no longer be responsible for submitting treatment authorization requests for EPSDT supplemental specialty mental health services to DHS for approval.

V. Memorandum of Understanding

Welfare and Institutions (W&I) Code Section 14651 requires DHS to ensure that Medi-Cal managed care contracts include a process for screening, referral, and coordination with any mental health plan. Consistent with this requirement, MCPs must enter into a

memorandum of understanding (MOU) with any MHP providing specialty mental health services to health plan enrollees. DMH currently is drafting guidelines to govern MOU development. MCPs may wait until final guidelines are issued before developing their MOU or they may wish to begin work on their MOU before final guidelines are available. At a minimum, the MOU should address the following points.

Referral Protocols

The MOU must specify the criteria to guide referrals from the MCP to the MHP, and vice versa. The MOU must specify how and when the MCP will provide a referral to the MHP when the MCP suspects that the enrollee has a mental health condition that would not be responsive to primary care. The MOU also must specify how and when the MHP will provide a referral to the MCP when the MHP determines that the MCP enrollee does not qualify for specialty mental health services. The MOU must specify the operational procedures for carrying out these referrals (e.g., specify the MC? and MHP contact persons responsible for processing referrals, the forms to be used when making referrals, and the time frames for taking action on a referral).

Exchange of Medical Records Information

The MOU must specify procedures for exchanging medical records information between MCPs and MHPs as necessary for the appropriate management of an enrollee's care. These procedures must ensure that the confidentiality of medical records is maintained in accordance with applicable federal and state laws and regulations as referenced below.

Medically Necessary Physical Health Care Services

The MOU must specify procedures for providing beneficiaries who require specialty mental health services with all medically necessary physical health care services for which the

MCP plan is contractually responsible. At a minimum, these procedures shall address the following: physician services; emergency room services; pharmaceutical services and prescription drugs; laboratory, radiological, and radioisotope services; home health agency services; medical transportation services; hospital outpatient department services; and physical health care services for psychiatric inpatient hospital patients.

Dispute Resolution Process

The MOU must specify procedures for resolving disputes between tie MCP and MHP. At a minimum, the MOU must specify how medically necessary specialty mental health services and physical health services will be delivered and reimbursed when a delay in the provision of services could result in l-farm to the beneficiary.

VI. Health Plan Responsibility for Mental Health Referrals

MCP PCPs who determine that an MCP enrollee is a potential candidate for specialty mental health services for an included diagnosis should refer 'the enrollee to the MHP for an assessment. MCP PCPs should refer MCP enrollees to the MHP only when, in. their judgement, the enrollee will meet the diagnosis, treatment, and intervention criteria outlined in Tables 3 and 4, or when they are unable to determine that the enrollee will meet these criteria. When making referrals to the MHP, MCP providers should use the referral protocols and procedures developed as part of the MCP's MOU with the MHP.

MCPs are responsibie for providing MC? enrollees whom they suspect would be ineligible for mental health treatment through the MHP with referrals to community agencies with an interest in mental health. MCPs may direct enrollees under the age of 21 to the local Child Health and Disability Prevention (CHDP) program for referrals to mental health providers and agencies. MCPs also may direct enrollees to other local agencies including: the Regional Center for referrals and services to the developmentally disabled; the Area

Agency on Aging for referrals to services for individuals aged 60 and over; the medical society; the psychological association; the mental health association; family service agencies; church sponsored social service agencies; substance abuse prevention and treatment agencies; community employment and training agencies; and county departments of alcohol and drug programs, mental health, and health and human services. The local information and referral telephone number also may be referenced as a resource.

MCPs must m&e available to health plan enrollees a current list of the names, addresses, and telephone numbers of local agencies with an interest in mental health. MCPs are not resyonsibie for linking health plan enrollees to these agencies. However, these referrals should be documented in the MCP enrollee's medical record.

VII. Confidentiality

MCPs must develop procedures to govern the exchange of patient medical record information between MCP and MHP providers. These procedures will be necessary to assure appropriate coordination of patient care and the timely provision of medically necessary services to MCP enrollees who require specialty mental health services. MCPs should consult with the local MHP when develop.ng these procedures, taking into consideration state and federal requirements governing beneficiary confidentiality and the release of medical records information. Procedures directing the exchange of patient medical information between MCP and MHP pi-oviders will be subject to county legal counsel's interpretation of these state and federal requirements. MCPs should refer to Titie 42, CFR, Section 43 I.300 et seq., Welfare and Institutions (W&I) Code Section 5328 et seq., W&I Code Section 14100.2, and Civil Code Section 56.10 et seq., and the reguiations adopted thereunder, when developing procedures to govern the exchange of patient medical record information.

If you need more information or have additional questions, please contact Mr. Alan Stolmack, Chief of the Policy Section, at (916) 653-5277.

Ann-Louise Kuhns, Chief
Medi-Cal Managed Care Division

Enclosures

TABLE 1

MENTAL HEALTH PLAN
SPECIALTY MENTAL HEALTH SERVICES

HCFA COMMON PROCEDURAL CODING SYSTEM (HCPCS) CODES	
90835 - 90899	X9500 - X9550
96100	Z0200
99201 - 99285	Z0202 - Z0210
99301 - 99376	Z0300
99450 - 99456	Z5814 - Z5816
99499	Z5820
Z7500, Z7502	

TABLE 2

MENTAL HEALTH PLAN

SPECIALTY MENTAL HEALTH DIAGNOSES

ICD-9-CM DIAGNOSIS CODES ALL PLACES OF SERVICE EXCEPT HOSPITAL INPATIENT					
295.00-298.9	299.1-300.89	301.0-301.6	301.8-301.9	302.1-302.6	302.8-302.9
307.1	307.3	307.5-307.89	308.0-309.9	311-313.82	313.89-314.9
		332.1-333.99	787.6		

ICD-9-CM DIAGNOSIS CODES HOSPITAL INPATIENT PLACE OF SERVICE					
290.12-290.21	290.42-290.43	291.3	291.5-291.89	292.1-292.12	292.84
295.00-299.00	299.10-300.15	300.2-300.89	301.0-301.5	301.59-301.9	307.1
307.20-307.3	307.5-307.89	308.0-309.9	311-312.23	312.33-312.35	312.4-313.23
313.8-313.82		313.89-314.9		787.6	

TABLE 3

MENTAL HEALTH PLAN MEDICAL NECESSITY CRITERIA

JUST HAVE *ALL*, A, B, *AND* C:

A. INCLUDED DIAGNOSES - COVERED BY MHP

Must have one of the following DSM IV diagnoses, which will be the focus of intervention.

- Pervasive Development Disorders, except Autistic Disorder
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorder;
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Note Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, Excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

EXCLUDED DIAGNOSIS - NOT COVERED BY MHP *

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorder
- Autistic Disorder
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorders
- Other Conditions except Medication-Induced Movement Disorders

• A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. IMPAIRMENT CRITERIA

Must have one of the following as a result of the mental disorder identified in A. Must have *one*, 1, 2, *or* 3.

1. A significant impairment in an important area of life functioning, *or*

2. A probability of significant deterioration in an important area of life functioning *or*

3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated.

C. INTERVENTION RELATED CRITERIA

Must have all, 1, 2, *and* 3

1 The focus of proposed intervention is to address the condition identified in impairment criterion B, *and*

2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*

3. The condition would not be responsive to physical health care based treatment.

Note: EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed to the substance use component, consistent with MHP treatment goals.

TABLE 4

RESPONSIBILITY FOR MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES DELIVERY						
DIAGNOSIS	PROGRAM	PSYCHIATRIST/ PSYCHOLOGIST	EPSDT SUPPLEMENTAL MFCC, LCSW, RN	PRIMARY CARE PROVIDER/ OTHER M.D. (%E09E OF FRACTICE MENTAL HEALTH SERVICES) (2)	FQHC, RHC, IHC SPECIALTY MENTAL HEALTH SERVICES	SPECIALTY MENTAL HEALTH ANCILLARY SERVICES (3) Rx, Laboratory, Medical Transportation, Home Health, Emergency Room Facility
MHP INCLUDED DIAGNOSIS AND MEETS MHP MEDICAL NECESSITY CRITERIA (1)	MHP	XXX	XXX			
	HEALTH PLAN					XXX
	FFS				XXX	XXX
MHP INCLUDED DIAGNOSIS AND DOES NOT MEET MHP MEDICAL NECESSITY CRITERIA	MHP					
	HEALTH PLAN			XXX		XXX
	FFS			XXX	XXX	XXX
MHP EXCLUDED DIAGNOSIS	MHP					
	HEALTH PLAN			XXX		XXX
	FFS	XXX	XXX	XXX	XXX	XXX

(1) Children covered under the EPSDT program qualify if they have a mental disorder which can be corrected or ameliorated, and would not be responsive to physical health care treatment.

(2) MCPs are responsible for primary care mental health services for MCP enrollees. The Medi-Cal FFS program is responsible for these services for FFS beneficiaries.

(3) MCPs are responsible for services ancillary to specialty mental health treatment for MCP enrollees, except when specifically excluded by contract. The Medi-Cal FFS program is responsible for these services for FFS beneficiaries, and MCP enrollees when these services are specifically excluded from the MCP's contractual responsibilities.

TABLE 5

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

Generic Name

Benztropine Mesylate
Biperiden HCL
Biperiden Lactate
Procyclidine HCL
Trihexphenidyl HCL
Amantadine HCL
Lithium Carbonate
Lithium Citrate
Chlorprothixene
Clozapine
Haloperidol
Haloperidol Deconoate
Haloperidoi Lactate
Loxapine HCL
Loxapine Succinate
Molindone HCL
Olanzapine
Pimozide
Risperidone
Thiothixene
Thiothixene HCL
Chlorpromazine HCL
Fluphanazine Decanoate
Fluphanazine Enanthate
Fluphanazine HCL
Mesoridazine Besylate
Perphenazine
Promazine HCL
Thioridazine HCL
Trifluoperazine HCL
Triflupromazine HCL
Isocarboxazid
Phenelzine Sulfate
Tranylcypromine Sulfate

EXHIBIT

UPDATED INFORMATION

Medi-Cal Bulletin

September 1997

Allied Health Services
Inpatient/Outpatient

Long Term Care
Medical Services

Specialty Mental Health Services
Consolidation Program Implementation

On November 1, 1997, the State Department of Mental Health (DMH) will begin implementing the Specialty Mental Health Services Consolidation Program for Medi-Cal recipients currently receiving or in need of professional mental health services in outpatient, clinic, inpatient hospital, nursing facility, home and community settings. This program expands the Psychiatric Inpatient Hospital Services Consolidation Program that has been in existence since January 1995.

Under the consolidation program, coverage for specialty mental health services will be provided through Mental Health Plans (MHPs) in California's 58 counties. In most cases, the MHP will be the county mental health department. MHPs render, or authorize and pay for specialty mental health services. This article addresses implementation of the consolidation program in Alameda (01), Kern (15), Placer (31), Riverside (33) and San Joaquin (39) counties on November 1, 1997. Future provider bulletins will announce additional county implementations.

Specialty Mental Health Services – Codes

Specialty mental health services covered by MHPs are Medi-Cal covered services listed on *Table 1* ("HCPCS Codes") that are delivered by an appropriately licensed specialty mental health provider to a recipient with a diagnosis specified in *Table 2* ("Specialty Mental Health Diagnoses – All Places of Services Except Hospital Inpatient") or *Table 3* ("Specialty Mental Health Diagnoses – Hospital Inpatient Place of Service").

HCPCS codes covered by MHPs are:

90835 - 90899	X9500 - X9550
96100	Z0200
99201 - 99285	Z0202 - 202 IO
99301 - 99376	Z0100
99450 - 99456	Z5814 - Z5816
99499	Z5820
	Z7500, Z7502

Table 1. HCPCS Codes.

ICD-9-CM diagnosis codes covered by MHPs are:

295.00 - 298.9	299.1 - 300.W	301.0 - 301.6	301.8 - 301.9	302.1 - 302.6	302.8 - 302.9
307.1	307.3	307.5 - 307.89	308.0 - 309.9	311 - 313.82	313.19 - 314.9
		332.1 -333.99	757.6		

Table 2. Specialty Mental Health Diagnoses - All Places of Services Except Hospital Inpatient

290.12 - 290.21	290.42 - 290.43	291.3	291.5 - 291.89	292.1 - 292.12	292.84
295.00-299.00	299.10 - 300.15	300.2 - 300.89	301.0- 301.5	301.59 - 301.9	307.1
307 20 - 307.3	307.5 - 307.89	308.0 - 309.9	311 - 312.23	312.33 - 312.35	312.4 - 313.23
	313.8 - 313.82	313.89 - 314.9	787.6		

Table 3 Specialty Mental Health Diagnoses – Hospital Inpatient Place of Service.

SPECIALTY MENTAL HEALTH SERVICES: CONSOLIDATION PROGRAM IMPLEMENTATION *(continued)*

Address/Telephone Number	Authorization Information
Riverside County Mental Health Plan Post Office Box 7549 Riverside, CA 92513 Local Number: (909) 358-4526 Toll Free Number: 1-800-706-7500	Non-emergency services require prior authorization. For information regarding provider contracts, contact B. J. Hughes at (909) 358-4526.
San Joaquin County Mental Health Plan 1212 North California Street Stockton, CA 95202 Toll Free Number: 1-888-468-9370	Non-emergency services require prior authorization. For information regarding contractual arrangements and/or plans for any necessary transition of clients, call Becky Gould at (209) 468-8859.

The following is a sample of the notice sent to Medi-Cal recipients affected by the specialty mental health services changes:

Notice to Medi-Cal Beneficiaries about Mental Health Benefits

The Medi-Cal program is changing the way people with Medi-Cal, including children, adults and older adults, receive mental health services in California. This change will happen in Alameda County on November 1, 1997.

Instead of people with Medi-Cal finding their own psychiatrist or therapist when they need mental health services from these kinds of providers, they will go to a mental health plan in each county for services. Mental health plans are managed care plans for mental health services. Mental health plans have already been providing people with Medi-Cal with mental health services in hospitals since 1995.

The mental health plan in Alameda County is Alameda County Behavioral Health Care Services. Their address is 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606. The toll-free number is 1-888-491-9099.

Most services will have to be approved ahead of time by the mental health plan before the psychiatrist or therapist can get paid for the service by Medi-Cal. This is a change from the regular Medi-Cal program. Approval by the mental health plan can happen quickly if a person needs mental health services right away. If a person needs to be admitted to a hospital for emergency mental health treatment, the hospital services do not have to be approved ahead of time.

When people with Medi-Cal think they may need mental health services, they should contact either their family doctor or the mental health plan. For most people with Medi-Cal currently receiving services from the county mental health system, there will be no change in how they get services. People with Medi-Cal currently receiving services from other psychiatrists or therapists should contact the psychiatrist, therapist or mental health plan to make sure that needed services are approved.

People may call the mental health plan's local or toll free number to get information about the mental health plan's services, including how people may get mental health services and what to do if they are unhappy about the services. The mental health plan has a brochure that also has that information. You may call the mental health plan to ask for a brochure or to ask for a list of the mental health plan's psychiatrists, therapists and clinics.

This change does not affect your rights under Medi-Cal. People who believe they need services still have access to the county's patients' rights advocate if they are concerned about their treatment. People with Medi-Cal will also have a right to submit a grievance to the mental health plan. People also have the right to request a Fair Hearing from the State within 90 days if they have a problem with denial, reduction, or termination of mental health services.

Figure 1. Sample Recipient Notice.